MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

03583

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County A. A

City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 HRS.

Hospital, institution, or street address where death occurred:
EMERGENCY HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDEL

City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)

Street No. 88 DOCK ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

GLORIA LOW ALTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) APRIL 7, 1945

8. AGE: Years — | Months — | Days 4 | If less than one day ____ hrs. ____ min.

9. Birthplace ANNAPOLIS, MD.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name RALPH L. ALTON
13. Birthplace CALVERT CO., MD.

MOTHER
14. Maiden name MARGARET V. ASBUITH
15. Birthplace A.A. CO., MD

16. Informant RALPH L. ALTON
Address 88 DOCK ST. ANNAPOLIS, MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof April 12/45 (month) (day) (year)

Cemetery or crematory CEDAR BLUFF CEMETERY

Location ANNAPOLIS, MD.

18. Funeral director B. L. HOPPING

Address 170-172 WEST ST. ANNAPOLIS, MD

19. April 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1945, at 2.20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 10, 1945 to April 11, 1945 and that I last saw h[illegible] alive on April 11, 1945

Immediate cause of death	DURATION
Congenital Atelectasis	3 hrs.
Due to	
Due to (asphyxia)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Albert L. Frederson M.D. M. D. of other

Address Annapolis, Md. Date signed 4/11/45

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 03584 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Texas County:
City or town: Fort Worth
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1414 W. Humbolt
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: James L. BALLOW ASN 18184545

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): 23 Oct 1926

8. AGE: Years	Months	Days	If less than one day
18	5	15	– hrs. – min.

9. Birthplace: Abiline, Texas (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margaret Gibson Ballow
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 7, 1945 (month) (day) (year)
Cemetery or crematory: Robertson, Muller & Harper Undertaking
Location: 1326 Penna Ave, Ft Worth, Texas.

18. Funeral director: Howard N. Blight
Address: Howard Blight 4914 Belair Rd., Baltimore, Md.

19. April 7, 1945 (Date rec'd by registrar) A.G. Brotzman, 2d Lt., Registrar MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1945 at 11:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~[illegible]~~ on April 6, 1945 ~~[illegible]~~ and that I last saw him alive on April 6, 1945

Immediate cause of death	DURATION
Meningitis meningococcic	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op.:
Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? (City or town) (County) (State) –
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: F. A. Kordecki, 1st Lt. MC
F.A. KORDECKI, 1st Lt., MC / M. D. or other
Address: Reg Hosp Ft Meade, Md. Date signed 4/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. G 95 MAY 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

03585 P

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel.
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maria Louise Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	B.	married.

6.(b) Name of husband or wife: Augustus Thomas Barnes
6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): Dec. 15 - 1871

8. AGE:	Years	Months	Days	If less than one day
73	75	8	3	hrs. min.

9. Birthplace: Bowie, Maryland.
(Town, county, and state)
10. Usual occupation: housewife.
11. Industry or business:

FATHER
12. Name: Bowie
13. Birthplace: Bowie, Maryland.

MOTHER
14. Maiden name: Minnie Bowie?
15. Birthplace: Bowie, Maryland.

16. Informant: Louise Edwards (daughter)
Address: Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/45 (month) (day) (year)
Cemetery or crematory: St. Stevens
Location: Harman, Md.
18. Funeral director: Elroy C. Wilson
Address: 1000 Brantley ave
19. 15 Apr 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1945, at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1945, to April 12 1945 and that I last saw her alive on April 11 1945.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hypertension	5
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: Gustave A. Pauter Md.
M. D. or other
Address: Glen Burnie, Md. Date signed 4/12/45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03586 23
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A. County
City or town: Linthicum Hgts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 614 S. MONROE St
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: WILLIAM S. BELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	MARRIED

6.(b) Name of husband or wife: Lindy May BELL
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): March 8-1877

8. AGE: Years	Months	Days	If less than one day
73	0	25	...hrs. ...min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Guard
11. Industry or business: Opd. Dept. Curtis Bay

FATHER
12. Name: FRANK BELL
13. Birthplace: Md

MOTHER
14. Maiden name: REBECCA ANN PAUL
15. Birthplace: Md

16. Informant: Lindy May BELL
Address: 614 S. MONROE St

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: April 6-1945 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: BALTIMORE Md

18. Funeral director: Pratt & B. M. Walters
Address: PRATT & STRICKER Sts.

19. 4/4 1945 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3rd 1945 at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3rd 1945, to April 3 1945
and that I last saw him alive on April 3 - 1945

Immediate cause of death	DURATION
Cancer of Liver	6 mos.
Due to	
Due to	
Other conditions Arteriosclerosis	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas L. Bell Jr. M.D.
M. D. or other
Address: Linthicum Date signed: 4-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03587 8.

Reg. Dist. No. 23

1. PLACE OF DEATH:
County A. A.
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel.
City or town Glen Burnie.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 211 - 11th Ave - South -
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Lucie L. Berges

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
F.	W.	married

6.(b) Name of husband ~~or wife~~ Pierre J. Berges.
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Dec. 2 - 1877

8. AGE: Years	Months	Days	If less than one day
67	4	28	hrs. min.

9. Birthplace Baltimore, (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. FATHER Name Conrad Schmidt.
13. FATHER Birthplace Germany. -
14. MOTHER Maiden name Mary Bissel
15. MOTHER Birthplace New Jersey -
16. Informant Pierre J. Berges.
Address 211 - 11th Ave - South - Glen Burnie Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 - 45 (month) (day) (year)
Cemetery or crematory Glen Haven Cem
Location
18. Funeral director Charles C. Powell
Address 2727 Edmondson Ave -
19. 5/1 1945 (Date rec'd by registrar) A. W. Fedrick per Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 about 2 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
sudden death - due to	
Coronary vascular disease	
Due to Hypertension	
Due to arterio - sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Conrad H. Paulsen MD M. D. or other
Address Glen Burnie Date signed 5/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

63588 Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 80 Gloucester St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph S. Bigelow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ernestine Bigelow
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 15th 1878

8. AGE: Years	Months	Days	If less than one day
67	2	2	..... hrs. ..... min.

9. Birthplace Brookline Mass
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Joseph S. Bigelow
13. Birthplace Mass.

MOTHER
14. Maiden name Mary E. Bryant
15. Birthplace Mass.

16. Informant Mrs Jos. S. Bigelow
Address 80 Gloucester St. Annapolis Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 19th 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Pri. Geo. Co. Md.

16. Funeral director John M. Sayler
Address Annapolis Md.

19. April 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945 at 10 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 8 1945, to April 16 1945
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to Chronic Endocarditis	20 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Cleffy M.D.
M. D. or other
Address Annapolis, Md. Date signed APR 18 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

03589

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft Meade, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
Company area

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: –

City or town: Roanoke
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1298 Rugby Blvd, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME Linwood E. BLANKENSHIP

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): May 23 1909

8. AGE:

Years	Months	Days	If less than one day
35	10	17	– hrs. – min.

9. Birthplace: Roanoke, Virginia
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mrs Allie T. (Unknown) Blankenship
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/9/45 (month) (day) (year)

Cemetery or crematory: John Oakey Funeral Home

Location: Roanoke, Virginia.

18. Funeral director: Howard Blight, Jr.

Address: 4914 Belair Rd, Baltimore, Md.

19. April 8 1945 (Date rec'd by registrar) A.C. BROTZMAN, 2d Lt MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 April 1945 at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I [redacted] viewed him on Apr 8 1945

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions: Partial cerebral hemiplegia	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Capt. R. H. Yoder MC
M. D. or other

Address: Reg Hosp, Ft Meade, Md. Date signed

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ba)

CERTIFICATE OF DEATH

03590

Reg. Dist. No. 27

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred: Regional Hospital
How long in hospital or institution? 5 months 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: -
City or town: New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 Pitt Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Frank - BROOKS ASN 6697275

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sallie (unknown) Brooks
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): January 28, 1910

8. AGE: Years	Months	Days	If less than one day
35	3	13	- hrs. - min.

9. Birthplace: Bluefield, W. Va. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 23 1945 (month) (day) (year)
Cemetery or crematory: E.J. Graziano, Undertaker
Location: 322 Delancey St., New York, N. Y.
Howard H. Blight Jr.

18. Funeral director: Howard Blight
Address: 4914 Belair Road, Baltimore, Md.

19. April 22, 1945 (Date rec'd by registrar) W.J.Lawson Jr. Registrar
W.J.LAWSON,JR., 1st Lt., MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1945, at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from xxxxxxxx April 22, 1945 and that I last saw him alive on April 22, 1945

Immediate cause of death	DURATION
Acute Myocarditis	6 months.
Due to: owing.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: J. H. Clark CMC
J. H. CLARKE, 1st Lt., MC M. D. or other
Address: Reg Hosp Ft Meade, Md. Date signed: Apr 23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

03591 P

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne-Arundel

City or town Rural - Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne-Arundel

City or town Rural - Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. Oakwood Rd RFD

(If rural, give LOCATION)

2.(a) If veteran, name war N

3.(a) FULL NAME Orson L Brown

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Single

6.(b) Name of husband or wife Mary E.

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1869

8. AGE: Years 76 | Months 3 | Days 18. | If less than one day ... hrs. ... min.

9. Birthplace Penna (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business (Retired)

FATHER 12. Name Unknown Brown

13. Birthplace Penna

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Miss Sylvia Brown

Address Oakwood Rd - Glen Burnie RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 28 1945 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Ann-Arundel County Md.

18. Funeral director Wm Cook Inc

Address Baltimore Md

19. 4/26/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1945 to April 25 1945 and that I last saw h... alive on April 25 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to Chronic Interstitial Nephritis	1 year
Due to Edema Endocardial Arteriosclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John L Alexander MD M. D. or other

Address Glen Burnie Md Date signed 4/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

03592

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A. A. Co.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Pleasant St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ella Brown

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife Richard Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	19	..... hrs. ..... min.

9. Birthplace Annapolis
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name William H. Brown

13. Birthplace A.A.Co.

MOTHER 14. Maiden name Martha Thomas

15. Birthplace A.A. Co.

16. Informant Susie Scott

Address Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30, 1945 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis

18. Funeral director J.B. Johnson

Address Annapolis, Md.

19. April 28, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945, at 1:00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from [illegible] 1944, to [illegible] 1945

and that I last saw h[illegible] alive on April 26, 1945

Immediate cause of death	DURATION
Carcinoma of Sigmoid (Colon)	5 months
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. R. H. Parkinson M. D. or other

Address 110 - Clay St. Annapolis, Md. Date signed 4/27/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03593

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 22 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: mmmmmm

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 224 South Fremont Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3. (a) FULL NAME: BROWN - JAMES #7

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1909

8. AGE: Years: 36 | Months: unknown | Days: | If less than one day: --- hrs. ---- min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: James Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Apr. 14, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundel County

18. Funeral director: Elroy Wilson

Address: 1000 Brantley Ave., Balto., Md.

19. 4/12 1945 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1945 at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 1945 to April 9 1945 and that I last saw him alive on April 9 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 2/2/45
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Earl L. Hinbrook M. D. or other

Address: Crownsville, Maryland Date signed: 4/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03594

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 523 South Greene Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---------

3.(a) FULL NAME: BURGESS - HARRISON

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	black	separated

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ----

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE:	Years	Months	Days	If less than one day
	48	unknown	---	--- hrs. ---- min.

9. Birthplace: South Carolina
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: Amos Burgess
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Nancy Weatherspoon
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Apr. 14, 1945 (month) (day) (year)
Cemetery or crematory: King's Tree
Location: South Carolina

18. Funeral director: Isaiah Brown & Son
Address: 108 W. Montgomery St., Balto., Md.

19. April 12 1945 (Date rec'd by registrar) Matilda L. DeAlton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1945 at 7:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1945 to April 11 1945 and that I last saw him alive on April 11 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 4/3/45
Due to: ----------	
Due to: ----------	
Other conditions ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of ------

Where did injury occur? (City or town) (County) (State) --------
Injured at home, farm, industry, public place (where?)
Means of injury ---------- Injured at work? ------

23. SIGNATURE: Harold L. Bourland M. D. or other
Address: Crownsville, Maryland Date signed 4/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

03595

CERTIFICATE OF DEATH

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Regional Hospital

How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Illinois County: —

City or town: Casey
(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 E. Madison
(If rural, give LOCATION)

2.(a) If veteran, name war: — ✓

3.(a) FULL NAME Harry M. CALLAHAN ASN 36,769,441

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ina B. Callahan

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 26, 1910

8. AGE: Years	Months	Days	If less than one day
34	8	17	— hrs. — min.

9. Birthplace: Casey, Ill.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Service Record

Address: U. S. Army

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 4 / 13 / 45
(month) (day) (year)

Cemetery or crematory: Cleone Manwell Undertaker

Location: Casey, Ill.

19. Funeral director: Howard M. Bligh Jr.

Address: 4914 Belair Road

19. 13 Apr 19 45
(Date rec'd by registrar)

A G BROTZMAN 2d Lt MAC
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 April 19 45 at 6:34 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 March 19 45 to 12 Apr 19 45 and that I last saw him alive on 12 Apr 19 45

	DURATION
Immediate cause of death: Pneumonia, left lower lobe, Rt lower lobe	8 days
Due to: Beta hemolytic Streptococcus	
Due to:	
Other conditions: Empyema left and right	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: J H Clark Lt MC
J H CLARK, Lt, M.C.
M. D. or other

Address: Reg Hosp Ft Meade Md Date signed: 14 Apr 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 357

CERTIFICATE OF DEATH

63596

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs. 10 Mo.

Hospital, Institution, or street address where death occurred: 83 West St. Annapolis Md.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 83 West St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Henry Chase

3. (b) Social Security Number: 214-18-8755

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): June 25, 1918

8. AGE: Years	Months	Days	If less than one day
26	10		....hrs. ....min.

9. Birthplace: EastPort A. A. Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER — 12. Name: William Alexander Chase

FATHER — 13. Birthplace: Annapolis Md.

MOTHER — 14. Maiden name: Mary Elizabeth Jones

MOTHER — 15. Birthplace: Annapolis Md.

16. Informant: Mr William Alexander Chase

Address: 83 West St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27/45 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. April 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 24 1945 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Post-mortem Examination to ..... 19.., and that I last saw h.. alive on Apr. 24 1945

Immediate cause of death	DURATION
General Paresis	2 years
Due to: Neuro-syphilis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatioos: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Cathey M.D. (Physician or Coroner)

Address: Annapolis. Md. 4/26/45 (Date signed)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03597

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs, 11 mos, 26 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 11 yrs, 11 mos, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown (If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: COARD - COLEY

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years	Months	Days	If less than one day
39	unknown		---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: Ambrose Coard
13. Birthplace: Unknown
MOTHER 14. Maiden name: Marlis Roberts
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. burial (Burial, cremation, or removal. Which?) Date thereof 4-27-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt.
Address:
19. Apr 27 1945 (Date rec'd by Registrar) E. Joyce Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1945, at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 1933 to April 15 1945 and that I last saw him alive on April 15 1945

Immediate cause of death: Lung Tuberculosis — DURATION: Since 12/31/43

Due to: ---

Due to: ---

Other conditions: Psychosis with Mental Deficiency — Known to us since 4/19/33
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert V. Brinkley M. D. or other
Address: Crownsville, Maryland Date signed: 4/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

03598

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 16 years
Hospital, institution or street address where death occurred:
85 Spa road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 87 Spa Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louise Allen Cook

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	married

6.(b) Name of husband or wife: Mathias Cook
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): April 1887

8. AGE: Years	Months	Days	If less than one day
58 58			hrs. min.

9. Birthplace: Harwood A-A-Co. Md.
(Town, county, and state)
10. Usual occupation: Laundress
11. Industry or business: none

FATHER
12. Name: Henry Bowie
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Eliza Johnson
15. Birthplace: Bristol Md.

16. Informant: Georgia Louise Isaacs
Address: 87 Spa Rd. Rd. Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/10/45 (month) (day) (year)
Cemetery or crematory: Bremen Hill Cemetery
Location: West Street

18. Funeral director: Ethel L. Hickey
Address: 45 Northwest St. Annapolis Md

19. April 9 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1945 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1944 to April 9 1945 and that I last saw h... alive on March 28 1945

Immediate cause of death	DURATION
Carcinoma of Cervix uteri	1yr +
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: as above.
Date of op.: 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. J. Klaware Md
M. D. or other
Address: 31 Southgate Av Date signed: 4/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

BCT

63600

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 29 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3421 Paton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: COOPER - JAMES

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years	Months	Days	If less than one day
84	unknown		---- hrs. ---- min.

9. Birthplace: Alabama
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: Henry Cooper
13. Birthplace: unknown

MOTHER
14. Maiden name: Kitty Christian
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18. Funeral director: Mrs. George A. Hull
Address: 1601 Druid Hill Ave.

19. April 30 1945 (Date rec'd by registrar) Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1944, to April 30 1945
and that I last saw him alive on April 30 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 12/21/44
Due to: ---------	
Due to: ---------	
Other conditions: ---------	

(Include pregnancy within 3 months of death)

Major findings of operations: --------

Date of op.: -----

Autopsy results: --------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: -----
Where did injury occur? -------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: -------- Injured at work? -----

23. SIGNATURE: Harl V. Mitchell M. D. or other
Address: Crownsville, Maryland Date signed: 4/30/45

M

VS A15

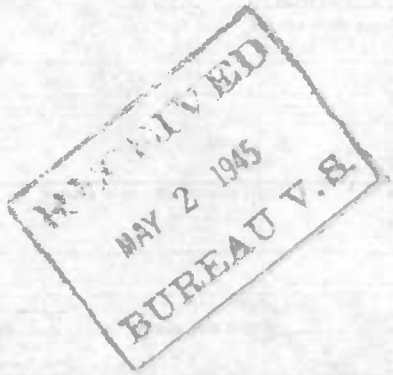
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

7

Mrs. George N. Holland
per. George Cuban Jr.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

03601

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Q. A.

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 4 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 923 Rutland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Dennis Carnisly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Black	

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 28, 1869

8. AGE: Years: 76 | Months: 1 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Thomas Carnisly

13. Birthplace: Md.

MOTHER — 14. Maiden name: - - - - -

15. Birthplace: - - - - -

16. Informant: Hospital records

Address: Crownsville Md

17. (Burial, cremation, or removal. Which?) Date thereof: 4 (month) 10 (day) 45 (year)

Cemetery or crematory: Mt Calvary Cem

Location: A. A. Co

18. Funeral director: Byron Maud Wright

Address: 721 Aisquith St

19. 4/8 45 E. Joyce Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1945, at 2 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26, 1945 to April 7, 1945 and that I last saw h... alive on April 7, 1945

	DURATION
Immediate cause of death: Chronic myocarditis, known to exist since Feb 26 1945	
Due to:	
Due to:	
Other conditions: Senile Psychosis known to exist since Feb. 26, 1945	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: ..... Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

63602

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Less than a day
Hospital, institution, or street address where death occurred: U S N Hospital, Annapolis Md
How long in hospital or institution? Less than a day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: N. J. County: Middlesex
City or town: Perth Amboy, N.J. (If outside city or town limits, write RURAL and give nearest town)
Street No. 591 Charles St. (If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: DABCZYNSKI, EDMUND MICHAEL
3.(b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): April 3, 1919
8. AGE: Years 26 Months - Days 3 If less than one day — hrs. — min.
9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: machine operator
11. Industry or business: U.S. Marine

FATHER
12. Name: Edmund M. Dabczynski
13. Birthplace: Poland

MOTHER
14. Maiden name: Mary Mac Dabczynski
15. Birthplace: Poland

16. Informant: Matthew Wolak
Address: 591 Charles St. Perth Amboy
17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 7/45 (month) (day) (year)
Cemetery or crematory:
Location: Carteret New Jersey
18. Funeral director: B. L. Hopping
Address: Annapolis Maryland
19. April 7, 1945 (Date rec'd by registrar) Wm. Ronnell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1945, at 7:58 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1945, to April 5, 1945
and that I last saw him alive on April 5, 1945

	DURATION
Immediate cause of death: Hemorrhage and Shock	
Due to: Gunshot wound, abdomen	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Abd. cavity found filled with blood unable to control bleeding. Date of op. April 5, 1945
Autopsy results: Rt. iliac vein cut, bullet in rt. iliac artery
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: April 5, 1945
Where did injury occur? Annapolis, Anne Arundel, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): On duty, U.S. Service
Means of injury: 45 cal. automatic Injured at work? Yes

23. SIGNATURE: James W. Hughes Jr. M.D. (M.D. or other) Lt. Comdr. (MC) USNR
Address: U.S. Naval Hosp. Annapolis, Md. Date signed: April 6, 1945

I

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03603

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2nd

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co

City or town: Linthicum Hts.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 Greenwood Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles E. Dawson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude Dawson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1880

8. AGE:

Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business:

FATHER — 12. Name: Luther Dawson

FATHER — 13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Margaret Mc Phail

MOTHER — 15. Birthplace: Baltimore - Md

16. Informant: Gertrude Dawson

Address: 301 W. Greenwood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore Md

18. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. April 28 1945 (Date rec'd by registrar) Mark Allen Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1945 at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 to April 27 1945 and that I last saw h.. alive on April 25 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage.	2 weeks
Due to: Cardio - Vascular Disease	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jam S. Buchanan M.D. M. D. or other

Address: Glen Burnie Md. Date signed: April 28, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

03604 7

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A A Co
City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: at Home
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A A Co
City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 Sycamore Road
(If rural, give LOCATION)
2.(a) Ll veteran, name war -No-

3.(a) FULL NAME Cornelia Ellen Disney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Chas. D. Disney.
6.(c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) October-8-1860

8. AGE: Years 84 | Months 5 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace A. A. Co. Md. (Town, county, and state)
10. Usual occupation (Linthicum Heights)
11. Industry or business None
12. FATHER Name Chas. Anderson
13. Birthplace A A Co. Md.
14. MOTHER Maiden name Hannah E. Moler
15. Birthplace Columbus-Ohio
16. Informant Mrs. Hazel L. Hill-(daughter)
Address 106 Sycamore Rd
17. Burial (Burial, cremation, or removal) Which? Date thereof Apr-6-45 (month) (day) (year)
Cemetery or crematory Temple Church Cemetery
Location Patuxent-A A Co. Md.
18. Funeral director Seward-Ulman Company
Address 108 W Monument St - Balto. Md.
19. 4/5 45 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945, at 2:15 P. M.
21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from Jan. 1945, to April 3 1945
and that I last saw h-r alive on April 3 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 days
Due to: Senile Arteriosclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James S. Buckingham M.D. M. D. or other
Address Glen Burnie Md. Date signed April 3 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

03605 21
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: a. a.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution~~ or street address where death occurred: Defense Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: a. a.
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2518 Ashton St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Edna MAY Emmons.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Arthur Emmons
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 17th 1893

8. AGE: Years	Months	Days	If less than one day
52	1	24	..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: John Wesley Ewald
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Sarah A. Weaver
15. Birthplace: Md.

16. Informant: Evelyn T. Woolford
Address: Defense Highway Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/14/45 (month) (day) (year)
Cemetery ~~or crematory~~: Mt Olivet
Location: Balto. Md.

18. Funeral director: William Cook Inc
Address: 127 St Paul St

19. 4/12/45 (Date rec'd by registrar) 19.... A. W. Hedrich Registrar
per HD

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11th 19 45, at 9:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 - 9 am 19 45, to April 11 - 9 am 19 45
and that I last saw h... alive on April 11 - 19 45

Immediate cause of death	DURATION
Coronary Thrombosis.	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo C Boerl M. D. or other
Address: Annapolis Md Date signed 4-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-1

03606

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frank Everhardt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. W. H. Tucker
Address: Edgewater P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 1945 (month) (day) (year)
Cemetery or crematory: County Home Cem.
Location: Edgewater
18. Funeral director: C. A. Saunders
Address: Galesville Md

19. May 1 1945 (Date rec'd by registrar) Edward Collemore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1944 to April 30 1945 and that I last saw h.im alive on April 27 1945

Immediate cause of death	DURATION
Chr. Myocarditis & Dem.	3 Mos.
Due to: Senility	
Due to:	
Other conditions: Senile Psychosis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. N. Clemens Md
M. D. or other
Address: 31 Southgate Ave Date signed 4/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03607 C.

Reg. Dist. No. 25

1. PLACE OF DEATH:
County A. A.
City or town BROOKLYN PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: 427 RIVERSIDE ROAD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town BROOKLYN PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 427 RIVERSIDE ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CHARLES H. FIFER

3.(b) Social Security Number 212-14-1338

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	MARRIED

6.(b) Name of husband or wife SABINA C. FIFER
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) October 2 - 189Y

8. AGE: Years	Months	Days	If less than one day
52	6	27	hrs. min.

9. Birthplace BALTIMORE Md
(Town, county, and state)
10. Usual occupation SHEET METAL
11. Industry or business
FATHER 12. Name JOHN FIFER
13. Birthplace —
MOTHER 14. Maiden name CLARA BLACKLEY
15. Birthplace —
16. Informant SABINA C. FIFER
Address 427 RIVERSIDE ROAD A.A. Co.
17. BURIAL Date thereof MAY 2-1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory HOLY REDEEMER CEM
Location BALTO MD
18. Funeral director Taff C & B.M. Walter
Address PRATT & STRICKER STS
19. 5/1 1945 Lee Nelson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th 1945 at 9:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945 to April 29 1945
and that I last saw h— alive on 4/27 1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Cushman M.D.
M. D. or other
Address 203 Calpen ave Date signed 4/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for addition of usual residence of deceased is shown on FILM No. G95 MAY 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24a)

CERTIFICATE OF DEATH

03608

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Lombardie Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nine years
Hospital, institution, or street address where death occurred: at Home —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Lombardie Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pasadena P.O.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frederick C. Framer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Katherine Gray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE:

Years	Months	Days	If less than one day
65	1	17	hrs. min.

9. Birthplace: Bellville, Texas (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business: Barber
12. FATHER — Name: John F. Framer
13. FATHER — Birthplace: Texas
14. MOTHER — Maiden name: Margaret Johnson
15. MOTHER — Birthplace: Texas
16. Informant: Mrs. Katherine Framer
Address: Lombardie Beach, Selby P.O.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 20, 1945 (month) (day) (year)
Cemetery or crematory: Savage Cemetery
Location: Howard County, Md.
18. Funeral director: Ridgely Selby
Address: Laurel Prince George Co. Md.
19. 4-20 1945 L.A.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1945, at 12 M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 9, 1945, to April 19, 1945
and that I last saw him alive on April 19, 1945

	DURATION
Immediate cause of death: Septicemia — Streptococcus	9 days
Due to: Infected sore upon Scrotum + Buttock	
Due to: Constant sitting in wheel chair caused sore	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other
Address: 1939 Edmondson Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03593

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. Severn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Paul Ezra Seaman

3.(b) Social Security Number 722-09-2889

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret L. Seaman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 20 - 1912

8. AGE: Years	Months	Days	If less than one day
32	7	5	..... hrs. ..... min.

9. Birthplace Carroll Co Md.
(Town, county, and state)
10. Usual occupation Employee Railway Express Agency
11. Industry or business

FATHER
12. Name A Clayton Seaman
13. Birthplace Carroll Co Md.

MOTHER
14. Maiden name Bessie Frock
15. Birthplace Carroll Co Md.

16. Informant Margaret L. Seaman
Address Severn Ave Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apl 28 - 1945 (month) (day) (year)
Cemetery or crematory St Annes
Location Annapolis Md
18. Funeral director John M. Taylor
Address Annapolis Md

19. April 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1945, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1945, to April 25 1945
and that I last saw h... alive on April 24, 1945

Immediate cause of death	DURATION
Paralyzed Lobes	4 days
Due to Cerebral Abstraction	5 days
Due to	
Other conditions Arteriosclerosis (Aorta) (Pregnancy) (Include pregnancy within 3 months of death)	7 days

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Albert H. Pederson M.D.
M. D. or other
Address Annapolis Md Date signed 4/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03609

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:
104 Clay Street

How long in hospital or institution? ********** ***

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Clay St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Roy Rudolph Green

3. (b) Social Security Number: 216-18-5220

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: * **********

6.(c) If alive, give age: ****

7. Birth date of deceased (mo., day, yr.): November 13, 1907

8. AGE: Years	Months	Days	If less than one day
37	4	20	...hrs. ...min.

9. Birthplace: Patuxent Prince George Co. Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: None

FATHER
12. Name: Harry Green
13. Birthplace: Taylorsville Md. A. A. Co.

MOTHER
14. Maiden name: Annie M. Taylor
15. Birthplace: Annapolis Md. A. A. Co.

16. Informant: Mrs Annie Green Thomas
Address: 104 Clay Street Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/ 6 /45 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West Street Extd.

18. Funeral director: Ethel L. Hicks

Address: 45 Northwest St. Annapolis Md.

19. April 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945 at 5 to 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1945 to April 3 1945 and that I last saw him alive on April 3, 1945

Immediate cause of death	DURATION
Cerebral apoplexy	12 days
Due to: Arterial Hypertension	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: R. L. Richardson M. D.

Address: Annapolis, Md. Date signed 4/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

03610

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address where death occurred:
32 College Creek Terrace

How long in hospital or institution? ********************

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 College Creek Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war ********************

3. (a) FULL NAME: Eward Gross

3. (b) Social Security Number: 214-05-2406

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs Ethel Gross

6.(c) If alive, give age **P years

7. Birth date of deceased (mo., day, yr.): August 17, 1907

8. AGE: Years	Months	Days	If less than one day
37	8		hrs. min.

9. Birthplace: Annapolis Md. A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: None

FATHER
12. Name: Julious Gross
13. Birthplace: West River Md.

MOTHER
14. Maiden name: Bertha Cook
15. Birthplace: Annapolis Md.

16. Informant: Mrs Ethel Gross
Address: 32 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/45 (mooth) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. April 21 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 19 45, at 8 45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 19 45 to April 19, 19 45 and that I last saw h.. alive on April 19, 19 45

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: T H Johnson M. d.
M. D. or other

Address: 35 Northwest St. Date signed: 4/20/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03611

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A. County, Maryland
City or town Glen Burnie (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County A. A. Co.
City or town Glen Burnie (If outside city or town limits, write RURAL and give nearest town)
Street No. 322 First Avenue So. (If rural, give LOCATION)
2.(a) If veteran, name war World War 1

3. (a) FULL NAME Edward C. Johnson - Grundstrom

3. (b) Social Security Number 215-01-6653

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife Pauline
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) February 2, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	0	... hrs. ... min.

9. Birthplace Hango, Finland (Town, county, and state)
10. Usual occupation Foreman
11. Industry or business Spedden Shipbuilding Co.

FATHER
12. Name Carl Grundstrom
13. Birthplace Finland

MOTHER
14. Maiden name Matilda (Unknown)
15. Birthplace Finland

16. Informant Mrs. Pauline Johnson Grundstrom
Address 322 First Ave. So. Glen Burnie

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-5-45 (month) (day) (year)
Cemetery or crematory U. S. National
Location Baltimore, Maryland
18. Funeral director William Cook, Inc.
Address 1217 St. Paul Street
19. 4-4 1945 (Date rec'd by registrar) B W Hadnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2-45 19 , at 5:50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15-44 19 to April 2-45 19
and that I last saw h— alive on April 2-45 19

	DURATION
Immediate cause of death Acute Cardiac Failure	4 hours
Due to	
Due to Cardio Renal Edema	6 mo.
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J R Spurtey M. D. or other
Address Glen Burnie Md Date signed April 3-45

I

T

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

03612

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 Pleasant Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Hall.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	widow

6.(b) Name of husband or wife: Georgana Hall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 17 1857

8. AGE: Years	Months	Days	If less than one day
88	0	25	hrs. min.

9. Birthplace: Prince George Co.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Thomas Hall
13. Birthplace: Md.
MOTHER 14. Maiden name: Nellie (unknown)
15. Birthplace: Md.
16. Informant: Annie Wilson
Address: 8 Pleasant Court
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 12 1945 (month) (day) (year)
Cemetery or crematory: Mt. Iglot
Location: Chesterfield, Dist.
18. Funeral director: J. B. Johnson
Address: Annapolis
19. April 12, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 9 1945 at 11:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1945, to April 9 1945
and that I last saw him alive on April 1 1945

Immediate cause of death	DURATION
Urinary Extravasation	2
Due to: Hypert. Cardiac (Benign)	1 Yr.
Due to:	
Other conditions: Gangrene of Scrotum & Penis	1 Mo.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. J. Klavans Md
M. D. or other
Address: 31 South Gate Av. Date signed: 4/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03613

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 9 mos., 27 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 yrs, 9 mos, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: --------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1600 Latrobe Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3.(a) FULL NAME
HARDEN - BESSIE

3.(b) Social Security Number
unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ---------
6.(c) If alive, give age: ---- years
7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 47 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ----

FATHER
12. Name: David Christian
13. Birthplace: unknown

MOTHER
14. Maiden name: Emma Coates
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 4/14/45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt Hospital
Address: Crownsville Md
19. (Date rec'd by registrar): 4/14 45 E F Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1945, at 6:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1940 to April 9 1945
and that I last saw her alive on April 9 1945

Immediate cause of death: Tuberculosis of the Lungs — DURATION: Known to us for 8 days
Due to: ----------
Due to:
Other conditions: Dementia Praecox — Known to us since June 1940
(Include pregnancy within 3 months of death)
Major findings of operations: ----------
Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: -------- Injured at work? --------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 4/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03614

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 years

Hospital, institution, or street address where death occurred:
16 Taylor St.

How long in hospital or institution? ********** *****

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro iofanta give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Taylor St.
(If rural, give LOCATION)

2.(a) If veteran, name war: **********

3. (a) FULL NAME

John Thomas HawkinsJr.

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Agnes Hawkins

6.(c) If alive, give age: **** years

7. Birth date of deceased (mo., day, yr.): October 7, 1879

8. AGE: Years	Months	Days	If less than one day
65 65	5		....hrs. ....min.

9. Birthplace: Broad Neck A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: None

FATHER
12. Name: John Thomas HawkinsSr.
13. Birthplace: Broad Neck A. A. Co. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Broad Neck A. A. Co. Md.

16. Informant: Mrs Agnes Hawkins
Address: 16 Taylor Street Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 / 9/45 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. Extd.

18. Funeral director: Ethel L. Hicks

Address: 45 Northwest St. Annapolis Md.

19. April 9 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/5 1945 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1945, to April 5 1945

and that I last saw h.. alive on April 5 1945

Immediate cause of death	DURATION
Uremia	2 yrs.
Due to: Nephrosclerosis	
Due to: Generalized Atherosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Sheridan G. Johnson M.D.
M. D. or other

Address: 35 Northwest Street Date signed: 4/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 95 MAY 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-2)

CERTIFICATE OF DEATH

03615

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New Jersey County: –
City or town: Elizabeth
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Hayes Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME John F. HAYES 32,278,817

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): April 14, 1914

8. AGE: Years	Months	Days	If less than one day
30 31-	11	23	– hrs. – min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Catherine (unknown) Hayes
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/7/45 (month) (day) (year)
Cemetery or crematory: John Morton Funeral Home, E. Jersey St, Elizabeth, N. J.
Location: Howard M. Blight 2
18. Funeral director: Howard Blight, Jr.
Address: 4914 Belair Road, Baltimore, Md.

19. 7 April 19 45 (Date rec'd by registrar) A G BROTZMAN 2d Lt MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 19 45 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 March 1945 to 6 April 1945 and that I last saw him alive on 6 April 1945

	DURATION
Immediate cause of death: Uremia	7 weeks
Due to: Chronic nephritis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op.:
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? – (City or town) – (County) – (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: F. A. Kordecki 1st Lt MC
F. A. Kordecki, 1st Lt M. D. or other
Address: Reg Hosp, Ft Meade, Md. Date signed: 7 Apr 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03616

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Monument St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bessie Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: William Johnson

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
70			____ hrs. ____ min.

9. Birthplace: Annapolis, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: John Robinson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Maria Robinson
15. Birthplace: Unknown

16. Informant: Wilda Prioleau
Address: New York

17. (Burial, cremation, or removal. Which?) Burial Date thereof: April 27, 1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis

18. Funeral director: J. B. Johnson
Address: Annapolis, Md.

19. April 27 1945 (Date rec'd by registrar) W. T. Francis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1945, at 12:50 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 12 1945, to April 22 1945
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Hypertensive Cardio-Vascular	1 yr.
Due to: Disease of Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Theodore K. Johnson M.D.
M. D. or other
Address: 35 Northwest Street Date signed: 4/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

CERTIFICATE OF DEATH

03617

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, institution, or street address where death occurred:
914 Spa. Rd.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 914 Spa. Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: **********

3. (a) FULL NAME: Carrie H. Johnson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William H. Johnson
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): August 24, 1890

8. AGE: Years	Months	Days	If less than one day
54 54	8		....hrs. ....min.

9. Birthplace: South River A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: None
FATHER 12. Name: William Hammond
FATHER 13. Birthplace: A. A. Co. Md.
MOTHER 14. Maiden name: Harriet Brown
MOTHER 15. Birthplace: A. A. Co. Md.
16. Informant: Mr William H. Johnson
Address: 914 Spa. Road Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/18/45 (month) (day) (year)
Cemetery or crematory: Fowlers Chapel Cemetery
Location: Best Gate Md.
18. Funeral director: Mrs Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.
19. April 18 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/14/45 19.... at 12 15 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14/45 19.... to ....19....
and that I last saw h.... alive on 4/14/45 19....

	DURATION
Immediate cause of death: Cardiac Failure	
Due to: Myocarditis	5 yrs.
Due to: Mitral Insufficiency	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Theodore H. Johnson M.D. M. D. or other
Address: 35 Northwest Street Date signed: 4/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (1)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

Reg. Diat. No. 03618 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 915 Boucher St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Reckler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry Reckler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1887

8. AGE: Years	Months	Days	If less than one day
57	6	3	..... hrs. ..... min.

9. Birthplace Phila Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Krauss
13. Birthplace Phila Pa

MOTHER
14. Maiden name Elizabeth Kress
15. Birthplace Phila Pa

16. Informant Harry Reckler
Address 915 Boucher St Eastport Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Apr 27 1945
(month) (day) (year)
Cemetery or crematory St Mary's
Location Annapolis, Md.
18. Funeral director John M. Taylor
Address Annapolis Md.

19. April 26 1945 Wm Donnell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 1945 to April 23 1945
and that I last saw her alive on April 23 1945

Immediate cause of death	DURATION
Coronary Thrombosis	11 days
Due to Coronary Sclerosis	unknown
Due to Diabetes Mellitus	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy, M.D.
(M. D. or other)
Address Annapolis, Md. Date signed 4/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

03619 27

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: FT. MEADE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 DAYS
Hospital, institution, or street address where death occurred:
ASF REGIONAL HOSPITAL, FT. MEADE MD.
How long in hospital or institution? 35 DAYS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: –
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: –
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME LEWELLYN, OLIVIA A.

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: William Lewellyn
6.(c) If alive give age: 63 years

7. Birth date of deceased (mo., day, yr.): October 12, 1886

8. AGE: Years	Months	Days	If less than one day
58	5	25	– hrs. – min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business: –

FATHER
12. Name: Un Known
13. Birthplace: Un Known

MOTHER
14. Maiden name: Un Known
15. Birthplace: Un Known

16. Informant: 1ST LT. ANNE LEWELLYN AUNT (DAUGHTER)
Address: ASF REGIONAL HOSP. FT. MEADE, MD.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 8 '45 (month) (day) (year)
Cemetery or crematory: William Cook Funeral Home
Location: Charles & St Paul, Balt md
18. Funeral director: Wm Cook dir Asst.
Address: 1217 St Paul St.
19. 8 April 1945 (Date rec'd by registrar) ALLAN G BROTZMAN, 2d Lt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 APRIL 1945 at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 MARCH 1945 to 8 APRIL 1945
and that I last saw her alive on 8 APRIL 1945

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	
Due to: CEREBRAL ARTERIOSCLEROSIS	2 1/2 YRS.
Due to: Accidental fall; March 1st, 1945	
Other conditions: FRACTURE, NECK OF RIGHT FEMUR	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of: March 1st 1945
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Pt's home of patient
Means of injury: Accidental fall. Injured at work? –

23. SIGNATURE: Edward L. Waisbrot Maj M.C. M. D. or other
Address: Regional Hosp. Ft. Meade Date signed: 8 Apr 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03621

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town 11 Jefferson
(If outside city or town limits, write RURAL and give nearest town)
Street No. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph E. Mabbett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna M. Mabbett
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feby 24th 1885

8. AGE: Years 60 | Months 2 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation Motorman B.&O. R.R.
11. Industry or business

FATHER
12. Name Edwin J. Mabbett
13. Birthplace Baltimore Md.

MOTHER
14. Maiden name Clarissa Marlnett
15. Birthplace Baltimore Md.

18. Informant Anna M. Mabbett
Address 11 Jefferson St. Annapolis Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Apr. 27-1945 (month) (day) (year)
Cemetery or crematory Woodlawn
Location Baltimore Co. Md.
18. Funeral director John M Taylor
Address Annapolis Md.

19. Apr 26 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 1945, to April 24, 1945
and that I last saw h... alive on April 24 1945

	DURATION
Immediate cause of death Cerebral Embolism	
Due to Thrombosis of the heart	2 Months
Due to Coronary Sclerosis	Some
Other conditions	4/19/45

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Albert H. Anderson M.D. M. D. or other
Address Annapolis Md. Date signed 4/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

03620

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mr Chesterfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills, Md R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles McDonald.

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): JUNE 187?

8. AGE:

Years	Months	Days	If less than one day
72	10	?	____ hrs. ____ min.

9. Birthplace: DUNBLANE, Scotland
(Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U.S. Army.
FATHER 12. Name: UNKNOWN
FATHER 13. Birthplace: UNKNOWN
MOTHER 14. Maiden name: UNKNOWN
MOTHER 15. Birthplace: UNKNOWN
16. Informant: Army Discharge Papers.
Address: States Attorney, Annapolis, Md
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof April 28, 1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cem.
Location: Arlington Va.
18. Funeral director: Thomas W. Sington
Address: New Burnie, Md
19. April 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about April 7th 1945 at ? M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__
and that I last saw h____ alive on ____ 19__

Immediate cause of death	DURATION
Cardio vascular disease.	
Due to: Senility	
Due to:	
Other conditions: Patient was found dead in Woodwards 4/24/45	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave A. Faucher M.D.
Medical Examiner M.D. or Coroner
Address: New Burnie Md Date signed 4/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

03622 P

Reg. Dist. No. 2

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 5 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Homeland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Locust Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace Michaelson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife alfred michaelson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 15 — 1868

8. AGE: Years	Months	Days	If less than one day
77	2	8	..... hrs. ..... min.

9. Birthplace Roumania (Town, county, and state)

10. Usual occupation Home work

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Benj Michaelson

Address annapolis. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24/45 (month) (day) (year)

Cemetery or crematory Eldswetgrad

Location Washington D.C.

18. Funeral director B. F. Hopkins

Address Annapolis. Md.

19. April 24 1945 (Date rec'd by registrar) W. Brandt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 22 1945 to April 23 1945 and that I last saw h.r alive on April 23 1945

Immediate cause of death	DURATION
Coronary Thrombosis	36 hrs.
Due to Arterial Hypertension	Several Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Oliver Parran M. D. or other

Address Annapolis Md Date signed 4/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 0362322

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 days
Hospital, institution, or street address where death occurred:
MARYLAND HOUSE OF CORRECTION
How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3002 Oakley Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME
ISADORE MILLER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Kate Miller
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Morton Miller
13. Birthplace: Russia

MOTHER
14. Maiden name: Ida Miller
15. Birthplace: Russia

16. Informant: MARYLAND HOUSE OF CORRECTION
Address: Jessups, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-22-45 (month) (day) (year)
Cemetery or crematory: Hebrew Cemetary
Location: Baltimore, Maryland
18. Funeral director: Jack Lewis, Inc.
Address: 1439 E. Baltimore St., Balto., Md.

19. Apr 21 19 45 (Date rec'd by registrar) Clara Kaslick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 17, 1945, to April 21, 1945
and that I last saw him alive on April 20, 1945

Immediate cause of death	DURATION
Lobar pneumonia, left lower and right middle lobes. Type not determined.	
Due to	
Due to	
Other conditions: Cardio-vascular disease. (Mitral insufficiency and arteriosclerosis.)	

(Duration — years, months, days)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A. Clark M. D. or other
Address: Jessups, Maryland Date signed: 4-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

03624

Reg. Diat. No. 21

1. PLACE OF DEATH:
County a a
City or town annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Yrs
Hospital, Institution, or street address where death occurred:
114 archwood ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a a
City or town annapolis md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 archwood ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anne C. Newton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Clarence O Newton
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 24 1895

8. AGE: Years	Months	Days	If less than one day
49	9	20	...hrs. ...min.

9. Birthplace Boston, mass
(Town, county, and state)
10. Usual occupation Home wife
11. Industry or business Keg mine
12. Name of FATHER Theodore J Cromar
13. Birthplace Scotland
14. Maiden name of MOTHER Christine B Cromar
15. Birthplace Scotland
16. Informant Clarence O. Newton
Address 114 archwood ave annapolis, md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15/45 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location annapolis md
18. Funeral director B. L. Hopkins
Address annapolis md
19. April 14 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13, 45 at 7.45 P.M.
21. I CERTIFY that death occurred on the date above stated; [redacted] deceased from the [redacted] Post-mortem Examination from Apr. 13 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	2 weeks
Due to	
Due to Coronary Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Raffy M.D. Deputy medical Examiner
M.D. or other
Address Annapolis Md Date signed 4/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T

03625

Reg. Diat. No. 23

1. PLACE OF DEATH: Anne Arundel Co.
County
Severn, Md. R.F.D.
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Severn, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cor. Crain Highway & New Cut Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna May Pumphrey

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Benjamin F. Pumphrey
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): February 8, 1891

8. AGE: Years	Months	Days	If less than one day
54	2	22	hrs. min.

9. Birthplace: Glen Burnie, A.A.Co, Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: own home

FATHER
12. Name: Edward T. Franklin
13. Birthplace: Baltimore Co, Md.

MOTHER
14. Maiden name: Ida Snyder
15. Birthplace: Glen Burnie, A.A.Co. Md.

16. Informant: Benjamin F. Pumphrey
Address: Severn, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Cedar Hill A.A.Co. Md.

18. Funeral director: Thomas W. Burgleton
Address: Glen Burnie Md.

19. May 2 1945 (Date rec'd by registrar) Mrs Della Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945, at 9.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1944, to April 30 1945
and that I last saw h alive on April 29 1945

	DURATION
Immediate cause of death: Carcinoma of the Liver	6 months
Due to: Carcinoma of the Rectum	2 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: operation on the Carcinoma of the Rectum Date of op. Feb 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James S. Buckingham M.D
M. D. or other
Address: Glen Burnie. Md Date signed May 2, (1945)

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 66

03626 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County MARYLAND ~~BALTI~~ ANNE ARUNDEL
City or town SHIPLEY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ANNE ARUNDEL
City or town SHIPLEY
(If outside city or town limits, write RURAL and give nearest town)
Street No. 406 OAK GROVE RD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JO ANN PUMPHREY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC. 10, 1941

8. AGE: Years	Months	Days	If less than one day
3	3	26	..... hrs. ..... min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name JOHN H. PUMPHREY
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden name ELSIE KEEPER
15. Birthplace FREDERICK MD

16. Informant JOHN H. PUMPHREY
Address 406 OAK GROVE RD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof APRIL 9, 1945 (month) (day) (year)
Cemetery or crematory LOUDON PARK
Location BALTIMORE MD

18. Funeral director ULLRICH FUNERAL HOME
Address 2008 ORLEANS ST

19. 4/7 45 C. W. Hedrick Reg'd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 6 19 45 at 2:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44 to April 6 19 45
and that I last saw h[illegible] alive on April 6 19 45

Immediate cause of death	DURATION
Hawley-Christian-Schulz Disease	15 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Chas. L. Bare Jr. M.D.
M. D. or other
Address [illegible] Date signed 4-6-45

STATE OF MARYLAND—CERTIFICATE OF DEATH 03627

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Brooklyn No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Annie L. Rossman

(a) Residence: No. 4405 Ritchie Highway St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	W	W.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Rossman.

6. DATE OF BIRTH (month, day, and year) Dec. 26, 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	3	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Maryland.
(State or country)

FATHER

13. NAME —

14. BIRTHPLACE (city or town)
(State or country)

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town)
(State or country)

17. INFORMANT Family
(Address) 4405 Ritchie Highway

18. BURIAL, CREMATION, OR REMOVAL
Place Holy Cross Date 4-18 1945

19. UNDERTAKER James L. McCully
(Address) Box 5 Odenton Md.

20. FILED 4-17 1945 [signature]
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 4 (Month) 14 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 19, 1945, to April 14, 1945

I last saw h— alive on 4/13/45, 19; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Heart failure due	
Chronic myocarditis	
Other Contributory Causes of Importance:	
Arthritis	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Samuel Rossman M. D.

(Address) 205 Catalpa Ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T 03628

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs., 11 mos., 3 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 8 yrs, 11 mos, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Mutual
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ----------

3.(a) FULL NAME: SANDERS - MARY

3.(b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ----------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1886 (?)

8. AGE: Years	Months	Days	If less than one day
59 (?)	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Domestic
FATHER 12. Name: Billie Sanders
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. burial (Burial, cremation, or removal. Which?) Date thereof 5-3-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt
Address
19. May 3 1945 (Date rec'd by registrar) E. J. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945, at 5:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1936 to April 20 1945
and that I last saw her alive on April 20 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Apprx. 8 yrs.
Due to: ----------	
Due to: ----------	
Other conditions: Paranoid Condition	Known to us since
Epileptic Seizures (Include pregnancy within 3 months of death)	5/17/36

Major findings of operations: ----------
Date of op.: ----------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: ----------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ----------

23. SIGNATURE: Albert J. Dinkards M. D. or other
Address: Crownsville, Maryland Date signed: 4/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03629 /

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A. Co. Md
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 706 Third Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elfriede Shields

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Shields
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): August 1 - 1872

8. AGE:

Years	Months	Days	If less than one day
72	8	17	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: none
11. Industry or business: —

FATHER
12. Name: Theodore De-Berger
13. Birthplace: Germany

MOTHER
14. Maiden name: Dorothea Wehmeyer
15. Birthplace: Germany

16. Informant: Irene C. Dudley
Address: 706 Third Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-20-1945 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D. C.

18. Funeral director: Flynn & Flanigan
Address: 1416 Light St.

19. APR. 20 1945 (Date rec'd by registrar) H. L. Pondrom Registrar
Dept. Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1945, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1943 19... to April 18 1945 and that I last saw h[illegible] alive on April 17 1945

Immediate cause of death	DURATION
Arterio-Sclerotic Cardio Vascular Renal Disease	
Due to: Cerebral Hemorrhage	
Due to: with Pulmonary Edema	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 320 Dorsey Lane Date signed 4/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1603)

03630

CERTIFICATE OF DEATH

Reg. Dist. No. 21

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County a a

City or town annapolis md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State maryland County a a

City or town eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Jackson St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Slider

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) april 16 1945

8. AGE: Years | Months | Days 2 | If less than one day 4 hrs. min.

9. Birthplace annapolis md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Alonzo B. Slider

13. Birthplace Cumberland md

MOTHER 14. Maiden name Elizabeth L Hrenko

15. Birthplace Primrose Pa

16. Informant Alonzo B. Slider

Address 100 Jackson St Eastport md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20/45 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location annapolis. md

18. Funeral director A. E. Hopkins

Address annapolis. md

19. April 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 18 1945 at 11 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 16, 1945 to Apr. 18, 1945 and that I last saw h... alive on Apr. 16 1945

Immediate cause of death	DURATION
Premature birth	7 mos.
Due to Hemorrhage due to	
Due to Separation of placenta	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M Cuffy M.D.
M. D. or other

Address Annapolis Md Date signed 4/19/45

VS A15

(M)

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (846)

CERTIFICATE OF DEATH

Reg. Dist. No. 03628

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 2 mos, 21 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 yr, 2 mos, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ----------
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2136 Brunt Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ----------

3. (a) FULL NAME: SMITH - JOHN
3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: --- years
7. Birth date of deceased (mo., day, yr.): 1919

8. AGE: Years	Months	Days	If less than one day
26	unknown		--- hrs. --- min.

9. Birthplace: Blackstone, Virginia
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: Edna Ford
15. Birthplace: Virginia
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Cremat (Burial, cremation, or removal. Which?) Date thereof: Apr 18. 45 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto City
18. Funeral director: A. A. Gaddis
Address: 2011 McCulloh St Balto
19. 4/15 19 45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1945, at 7:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23, 1944, to April 14, 1945, and that I last saw him alive on April 14, 1945.

Immediate cause of death: Schizophrenia — DURATION: known to us since 1/23/44
Due to: ---------
Due to: ---------
Other conditions: ----------
(Include pregnancy within 3 months of death)
Major findings of operations: ---------
Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --------- Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---------
Means of injury: ------- Injured at work? -----

23. SIGNATURE: [illegible signature] M. D. or other
Address: Crownsville, Maryland Date signed: 4/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (304)

03632

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1615 McCulloh Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: SMITH - LUCY IRENE

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): March 2, 1904 (?)

8. AGE: Years	Months	Days	If less than one day
41?	1	22	-- hrs. --- min.

9. Birthplace: St. Mary's County, Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ---

FATHER
12. Name: Ambrose Gaugh
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucy Butler
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Apr. 28, 1945 (month) (day) (year)
Cemetery or crematory: St. Peter's Cemetery
Location: Baltimore City

18. Funeral director: Mrs. Geo. H. Holland
Address: 1631 Druid Hill Ave., Balto., Md.

19. April 26 1945 (Date rec'd by registrar) Mrs. Allen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 19 45 at 3:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 45 to April 24 19 45 and that I last saw her alive on April 24 19 45

Immediate cause of death	DURATION
General Paresis	Known to us since 4/23/45
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Allen V. Armiger M. D. or other
Address: Crownsville, Maryland Date signed: 4/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

03633

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 160 Conduit
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Virgie T. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William A. Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 31st 1886

8. AGE: Years 59 | Months | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace A A Co Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name John R. Lee
13. Birthplace A A Co Md.

MOTHER 14. Maiden name Mary E. Collinson
15. Birthplace A A Co Md

16. Informant William A. Smith
Address Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15th 1945 (month) (day) (year)

Cemetery or crematory Cedar Bluff
Location Annapolis Md

18. Funeral director John W. Layla
Address Annapolis Md

19. April 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945 at 5-50P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 1944 to April 12 1945 and that I last saw her alive on April 12 1945

	DURATION
Immediate cause of death Carcinomatosis from Cancer of Stomach with Metastasis to	6 months
Due to Stomach chest & neck.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to extereal causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Buell M. D. or other
Address Annapolis Md Date signed 4-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03634

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: ~~Baltimore~~ Anne Arundel
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 109 Third Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Anne Arundel ~~Balto.~~
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Third Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME NELLIE SNYDER
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: James H. Snyder
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 28, 1880

8. AGE: Years	Months	Days	If less than one day
64	6	13	... hrs. ... min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Borden
13. Birthplace: Norway

MOTHER
14. Maiden name: Ellen Dewees
15. Birthplace: Philadelphia, Pa.

16. Informant: Mr. James H. Snyder
Address: 109 Third Ave., Brooklyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/14/45 (month) (day) (year)
Cemetery or crematory: Krider's Cem.
Location: Westminster, Md.

18. Funeral director: WM.J. TICKNER & SONS
Address: Balto., Md.

19. 4/12 45 (Date rec'd by registrar) G. W. Hedrick per ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 19 45, at 1:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 45 to April 11 19 45
and that I last saw her alive on April 11 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	40 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: P. J. Grimaldi M.D. (M. D. or other)
Address: 4609 Gov. Ritchie Hway Date signed: 4-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-M)

CERTIFICATE OF DEATH

03635 P

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hanover -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 10 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1609 - Lombard St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Georges E. Soan (SOAN)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
W.	W.	M.

6.(b) Name of husband or wife: Susie
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: Bethlehem Steel Co.
FATHER 12. Name: M. Soan
FATHER 13. Birthplace: Pa.
MOTHER 14. Maiden name: ? - - -
MOTHER 15. Birthplace: Pa
16. Informant: Susie Soan
Address: 246 S. Chapel St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1/45 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Baltimore
18. Funeral director: Fred W. Ozarowski
Address: 1930 Eastern Ave.
19. 5/1 19 45 (Date rec'd by registrar) A. W. Hedrick per EO (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: about April 15 19 45 ? at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
asphyxia due to carbon monoxide	
Due to: was found in his car -	
Due to: parked - in the woods -	
on Mrs. Dowell farm - Hanover	
Other conditions: Maryland - on 4/29/45	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: about 4/15/45
Where did injury occur? Hanover, A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) car. (automobile)
Means of injury: Carbon monoxide Injured at work? No

23. SIGNATURE: Gustave H. Rauder M.D.
Medical Examiner M. D. or other
Address: Glen Burnie, Md. Date signed: 4/30/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03636

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George B. Stinchcomb

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Ann Eleanor Stinchcomb
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 8th 1864

8. AGE:

Years	Months	Days	If less than one day
80	10	6	hrs. min.

9. Birthplace: A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: William Stinchcomb
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Rosina Pumphrey
15. Birthplace: A. A. Co. Md.

16. Informant: Mrs. Lue A. Jenkins
Address: Pasadena A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Prahue Highway A. A. Co. Md.

18. Funeral director: John W. Taylor
Address: Annapolis Md.

19. April 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1945, at 9:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 14 1945 and that I last saw h... alive on April 14 1945

	DURATION
Immediate cause of death:	
Bronchopneumonia	14 days
Due to: (Secondary)	
Due to:	
Other conditions: Arteriosclerosis Cardio-Vascular disease	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis, Md. Date signed: 4/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03637

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ft Geo G Meade
(If outside city or town limits, write RURAL and give nearest town)
Street No.: NCO Qrs 121
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Helen I. TRAMER

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albert Tramer
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): January 15, 1923

8. AGE: Years	Months	Days	If less than one day
22	3	0	– hrs. – min.

9. Birthplace: Knoxville, Tenn (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: M. C. Widly
13. Birthplace: St Louis, Mo.

MOTHER
14. Maiden name: Nora Jean Bean
15. Birthplace: Knoxville, Tenn.

16. Informant: Albert Tramer
Address: NCO Qrs 121, Ft Geo G Meade, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/15/45 (month) (day) (year)
Cemetery or crematory: Frank Rose Funeral Home
Location: Knoxville, Tenn.

18. Funeral director: Howard M. Blight Jr.
Address: 4914 Belair Road.

19. Apr 14, 1945 (Date rec'd by registrar) W.J. Lawson Jr.
W.J. LAWSON, JR., 1st Lt. Registrar
MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1945, at 8:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1945, to April 14, 1945
and that I last saw her alive on April 14, 1945

Immediate cause of death	DURATION
Ill-defined condition of abdomen manifested by symptoms of append-	
Due to: xxx icitis, ascites, hypoalbumine-	
Due to: mia and sepsis	1 month
Due to: –	
Other conditions: –	

(Include pregnancy within 3 months of death)

Major findings of operations: Appendectomy; dilatation and curettage Date of op. 17 Mar 45
Autopsy results: None performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: John C. Clark Capt
JOHN C. CLARK, Capt., MC M. D. or other
Address: Reg Hosp Ft Meade Md Date signed: Apr 14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1945

03638

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Tyler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COL.	Widowed

6.(b) Name of husband or wife: Eliza Tyler
6.(c) If wife, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Ida Tyler
Address: Lothian

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Apr 30 1945
(month) (day) (year)
Cemetery or crematory: Adams
Location: Lothian

18. Funeral director: W. C. Handley & Son
Address: Galesville Md.

19. April 30 1945
(Date rec'd by registrar)
W. M. Clarke
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to April 28 1945
and that I last saw h[illegible] alive on April 5 1945

Immediate cause of death: Pulmonary Thrombosis — DURATION
Due to: Chronic Nephritis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F B Hunt M. D. or other
Address: Lothian Md. Date signed: 4/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

03639

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Near Glen Burnie, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Oakwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anton Velerovsky

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Anna Velenovsky
Nee Slechta
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 19, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	16	..... hrs. ..... min.

9. Birthplace: Praha Czechoslovakia
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Farmer

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Frank Wimmer Jr.
Address: Glen Burnie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1945 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore Md
18. Funeral director: Thomas W Singleton
Address: Glen Burnie, Md.

19. 4/6/ 1945 M. R. Dealaber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1945 at 7.15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16th 1945 to 4/5/45 1945
and that I last saw h... alive on 4/4/45 1945

Immediate cause of death: Coronary Thrombosis — Duration: 10 min.
Due to: Chronic Endocarditis — 1 year
Due to: Arteriosclerosis — 1 year
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John [illegible] M. D. or other
Address: Glen Burnie Date signed 4/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03640

Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-1

1. PLACE OF DEATH:

County Ha

City or town Jewell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Ha

City or town Jewell

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Christine Wilkinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	M

6.(b) Name of husband or wife Marion Wilkinson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1895

8. AGE: Years	Months	Days	If less than one day
50	3	27	..... hrs. ..... min.

9. Birthplace Md

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Harris

13. Birthplace Md

MOTHER 14. Maiden name Fanny Simms

15. Birthplace Md

16. Informant Marion Wilkinson

Address Jewell Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 24-1945 (month) (day) (year)

Cemetery or crematory Lee Sinai Cem

Location Baltimore Md

18. Funeral director R. B. Stevens

Address Catonsville Md

19. April 24 45 H. B. Clayton

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 21 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945, to 4/21 1945

and that I last saw her alive on 4/21 1945

Immediate cause of death	DURATION
Malignant hypertension	3 mos
Due to Cerebral hemorrhage	3 dys
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Clayton M. D. or other

Address Jewell Md Date signed 4/24/45

BCT 03641

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Baltimore City ~~Crownsville~~

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs, 9 mos, 2 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 5 yrs, 9 mos, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2104 McCulloh Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: WILKENS - LOTTIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Colonel Wilkens

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years: 35 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Housework

FATHER — 12. Name: Wilmer Mills

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Cora Manuel

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which? burial Date thereof: 5/3/45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Hospital

Address

19. (Date rec'd by registrar) May 3 1945 Registrar: E Joyce Doar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1945 at 6:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1939 to April 19 1945

and that I last saw her alive on April 19 1945

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 3/2/45
Due to: ---	
Due to:	
Other conditions: Schizophrenia - Paranoid Type (Include pregnancy within 3 months of death)	known to us since 7/17/39

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? (City or town) (County) (State) ---

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 4/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03642

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs, 3 mos, 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 yrs, 3 mos, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
unknown
2.(a) If veteran, name war: V

3. (a) FULL NAME
WILLIAMS - JACK

3. (b) Social Security Number
unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---------
6.(c) If alive, give age: -------years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years: 32 | Months: unknown | Days | If less than one day: ---hrs. ---min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-18-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville, Md.

18. Funeral director: Supt. of Hospitals
Address:

19. Apr 18 1945 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1942, to April 17 1945
and that I last saw him alive on April 17 1945

	DURATION
Immediate cause of death: Tuberculosis of the Lungs	Known to us since 3/5/45
Due to: ----------	
Due to: ----------	
Other conditions: Psychosis with Mental Deficiency	Known to us since 1/8/42

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: -------
Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Albert J. Winbrow M. D. or other
Address: Crownsville, Maryland Date signed: 4/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

03643 P

CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Patapsco Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: A. A.
City or town: Patapsco Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dennis Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Wright
3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	B.	Widowed.

6.(b) Name of husband or wife: Caroline Smith.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
	?	?	hrs. min.

9. Birthplace: ? (Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business:
FATHER 12. Name: George Wright.
13. Birthplace: ?
MOTHER 14. Maiden name: ?
15. Birthplace:
16. Informant: Isoldie Wright (daughter)
Address: Patapsco Park, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/20/45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn St
Location: Balto. City
19. Funeral director: Isaiah L. Brown & Son
Address: 108 W Montgomery St
19. 4/20 1945 (Date rec'd by registrar) A. W. Bedard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945, at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Sudden death due to Cerebral Hemorrhage.	
Due to: Hypertension.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Bauer M.D. M. D. or other
Address: Glen Burnie, Md. Date signed: 4/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

03644

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Waugh Chapel (Odenton Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Herold Harbor (Crownsville, Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Edward Yoekel

3.(b) Social Security Number: 216-18-5397

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Mary E. Yoekel
Nee Burkhardt. 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): November 8, 1866

8. AGE: Years: 78 | Months: 5 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Prince George County
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

MOTHER FATHER
12. Name: George C. Yoekel
13. Birthplace: Germany
14. Maiden name: Mary — Unknown
15. Birthplace: Germany

16. Informant: L. Edward Yoekel
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April-25, 1945 (month) (day) (year)
Cemetery or crematory: Baldwins Meno Ch. Yard
Location: Severn Cross Roads, (Millersville Md. P.O.)
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. April 25 1945 (Date rec'd by registrar) Matthew B. Deale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22nd 1945 at 4.33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1945 to April 22 1945 and that I last saw h... alive on April 22 1945

Immediate cause of death: Uremia — DURATION: 10 da

Due to: Nephritis, Acute — 3 wks

Due to:

Other conditions: Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: O. H. M. Kemp M. D. or other
Address: Millersville Md. Date signed: 4-23 45